

# Employee Paperwork Checklist



## Instructions

- Check off all required forms and any optional items when completed.
- Keep this page as a reminder to submit any outstanding forms.
- **RETURN** all completed forms and documentation **to your supervisor or Administaff representative.**

To find the fax number for your Administaff payroll specialist, call 866-715-3552 or go to Contact Us on [administaffservices.com](http://administaffservices.com).

## Welcome to Administaff!

This booklet contains employment forms required to become employed with Administaff as well as policies, and forms for optional benefits programs.

**Note:** All Social Security numbers are subject to verification with the Social Security Administration.

Employee First Name	Employee Last Name	Last 4 Digits of Social Security Number
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**POLICIES** – Read and retain for your personal records.

- ✓ Anti-Harassment Policy ..... 3
- ✓ Family and Medical Leave Policy / Employee Rights and Responsibilities ..... 5

**REQUIRED FORMS** – Submit to Administaff **on or before your date of hire.**

- ☐ New Employee Information Sheet ..... 11-13
- ☐ W-4 — Employee's Withholding Allowance Certificate ..... 15
- ☐ I-9 — Employment Eligibility Verification ..... 21
  - ☐ Photocopies of I-9 supporting documents (see I-9 form)
- ☐ Employment Agreement ..... 23-25
- ☐ Policy Acknowledgments ..... 27

**State-Specific Forms** (may be included or inserted in this booklet)

- ☐ State tax withholding form(s) *where applicable*
  - Colorado** ☐ I-9 Affirmation Regarding Work Status
  - Hawaii** ☐ HC-5 Employee Notification to Employer
  - Maryland** ☐ Maryland Employee Notice
  - New Hampshire** ☐ New Hampshire Employee Notice
  - New Jersey** ☐ Family Leave Insurance Provisions
  - New York** ☐ New York Employee Notice
  - Pennsylvania** ☐ Resident Tax Jurisdiction
  - ☐ Workers' Compensation Information Acknowledgment
  - South Carolina** ☐ Terms of Employment Notice
- ☐ Other state-specific form(s) where applicable

**OPTIONAL FORMS** – Submit as needed.

- ☐ Direct Deposit with ePayStub Enrollment/Change Request ..... 29
- ☐ Deduction Authorization ..... 31

# Your Administaff Contacts

## The Employee Service Center<sup>SM</sup>

*Find answers to your questions online any hour, any day.*

ONLINE: **www.administaffservices.com**

### Create an account:

You may create an Employee Service Center account a few days after we receive your required paperwork, which must be submitted on or before your Administaff date of hire\*.

### Visit the Employee Service Center:

- For more information about Administaff and services we provide.
- For answers to general benefit questions and forms.
- To view your pay information, change direct deposit, change your address or other personal information.
- To take an online training class, enroll for commuter benefits or learn about other benefits of co-employment with Administaff.
- To learn about MarketPlace offers and discounts.



### Why Wait?

Access your information 24/7.

More than 250,000 employees have created an account on the Employee Service Center. Visit us at **administaffservices.com** and find out what you may be missing!

You can create a new account within a few days after we process your employee paperwork.

## The Administaff Contact Center

*Weekdays between 7 a.m. and 7 p.m. Central time*

PHONE: **866-715-3552**

E-MAIL: **contact\_center@administaff.com**

This is a comprehensive customer assistance system of information resources that can support you at every stage of your Administaff experience.

### Call the Administaff Contact Center when you:

- Need help logging into the Employee Service Center or locating specific information.
- Have questions regarding your benefits enrollment options.
- Have contacted your insurance carrier and its records show that you are not active in its system.
- Have questions about your 401(k) retirement plan options.

### Turn in Paperwork Today!

Turn in all required employment paperwork **on or before your Administaff date of hire\*** to ensure your first payroll can be run on time.

*Use the Employee Paperwork Checklist on page 1 to make sure you submit all required items.*

\* Your Administaff date of hire is your first day as a paid employee on Administaff's payroll.

## Administaff Locations

### Atlanta Service Center

1940 Lodge Rd. NW,  
Suite 100  
Kennesaw, Georgia 30144-7577  
**877-239-6090**

### Dallas Service Center

545 E. John Carpenter Frwy.,  
Suite 1200  
Irving, Texas 75062-3931  
**800-303-9611**

### Houston Service Center

4101 Interwood North Pkwy.,  
Suite 100  
Houston, Texas 77032-3864  
**888-917-9038**

### Los Angeles Service Center

1440 Bridge Gate Dr.,  
Suite 100  
Diamond Bar, California 91765-3922  
**866-591-6678**

### Corporate Headquarters

19001 Crescent Springs Drive  
Kingwood, Texas 77339-3802  
**800-242-8893**



**[EMPLOYEE: KEEP THIS COPY FOR YOUR RECORDS]**

It is the policy of the Company to maintain a working environment that encourages mutual respect, promotes respectful and congenial relationships between employees and that is free from all forms of harassment by anyone, including supervisors, co-workers, vendors, contractors or customers. Harassment, even when not unlawful or directed at a protected category, is expressly prohibited and will not be tolerated by the Company. Accordingly, Company management is committed to vigorously addressing complaints of harassment, sexual harassment and discrimination at all levels within the Company.

Reported or suspected occurrences of harassment or discrimination will be promptly and thoroughly investigated. Following an investigation, the Company will promptly take any necessary and appropriate disciplinary action.

The Company will not permit or condone any acts of retaliation against anyone who files harassment or discrimination complaints or cooperates in the investigation of same.

1. The term "harassment" includes harassment based on any category protected by federal, state or local law, which may include depending on the jurisdiction, but is not limited to, unwelcome slurs, jokes, or verbal, graphic or physical conduct relating to an individual's race, color, religious creed, sex, national origin, ancestry, citizenship status, pregnancy, childbirth, physical disability, mental disability, age, military status or status as a Vietnam-era or special disabled veteran, marital status, registered domestic partner or civil union status, gender (including sex stereotyping and gender identity or expression), medical condition (including, but not limited to, cancer related or HIV/AIDS related), genetic information or sexual orientation.
2. Sexual harassment consists of unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature where:
  - a. Submission to such conduct is an explicit or implicit term or condition of employment;
  - b. Employment decisions are based on an employee's submission to or rejection of such conduct; or,
  - c. Such conduct unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment.

**Complaint Procedure**

The Company provides its employees with a convenient and reliable method for reporting incidents of alleged harassment, including sexual harassment and discrimination. Any employee who feels harassed or discriminated against is encouraged to immediately inform the alleged harasser that the behavior is unwelcome. In many instances, the person is unaware that his or her conduct is offensive and when so advised can easily and willingly correct the conduct so that it does not reoccur. If the informal discussion with the alleged harasser is unsuccessful in remedying the problem or if you do not feel comfortable with such an approach, you should immediately report the conduct to your immediate supervisor, manager or owner of the Company and and the Administaff Anti-Harassment hotline number at 800-242-8893, ext. 3000 or 281-312-3000 in the Houston area. We cannot help resolve a harassment or discrimination problem unless we know about it. Therefore, it is your responsibility to bring those kinds of problems to our attention so that we can take the necessary steps to correct the problem. The report should include all facts available to the employee regarding the alleged harassment or sexual harassment or discrimination.

When you call the Administaff Anti-Harassment Hotline, please leave your name, Administaff employee identification number or the last four (4) digits of your social security number and the name of the Client Company for which you work. If you wish to make an anonymous complaint, you may do so, but the scope of our investigation may be limited based on the information you provide.

**Confidentiality**

All reports of alleged harassment, sexual harassment or discrimination will be treated seriously. It will be kept confidential, and it will be shared only with those who have a need to know about it. Depending on the circumstances, that could include the alleged harasser. However, absolute confidentiality is not promised nor can it be assured.

**Investigative Procedure**

Once a complaint of alleged harassment or sexual harassment or discrimination is received, the Company will begin a prompt and thorough investigation. The investigation may include interviews with all involved employees, including the alleged harasser, and any employees who are aware of facts or incidents alleged to have occurred.

Following an investigation, the Company will promptly take any necessary and appropriate disciplinary action. Disciplinary action will be taken if the investigation reveals that an employee has acted in a manner that is not in alignment with the goal of this policy, even when the actions may be lawful. In fact, the Company may address any workplace issue discovered during an investigation. This may include some or all of the following steps:

1. Restore any lost terms, conditions or benefits of employment to the complaining employee.
2. Discipline the alleged harasser. This discipline can include written disciplinary warnings, transfer, demotion, suspension, and termination.

If the alleged harassment or sexual harassment is from a vendor, contractor or customer, the Company will take appropriate action to stop the conduct.

If you have made a complaint but feel that the action taken in response has not remedied the situation, you should make a complaint following the complaint procedure outlined in this policy.

### **Duties of Employees and Supervisors**

All employees of the Company, both management and non-management, are responsible for assuring that a workplace free of harassment or sexual harassment and discrimination is maintained. Any employee may file a complaint regarding incidents experienced personally or incidents observed in the workplace. The Company strives to maintain a lawful, pleasant work environment where all employees are able to effectively perform their work without interference of any type and requests the assistance of all employees in this effort.

All Company supervisors and managers are expected to adhere to the Company's Anti-Harassment Policy. Supervisors' evaluations may include an assessment of a supervisor's efforts in following and enforcing this policy.

All managers and supervisors are responsible for doing all they can to prevent and discourage harassment, sexual harassment and discrimination from occurring. If a complaint of harassment or sexual harassment or discrimination is raised, the individual to whom the complaint is made (i.e., supervisor, manager, owner of Client Company) should act promptly to notify the Administaff Anti-Harassment hotline number of the complaint so that Human Resources may proceed with an investigation. If such individual fails to follow this policy, he or she will be disciplined. Such discipline may include termination.

### **California Employees Only**

Any form of harassment or discrimination which violates federal, state or local law, including, but not limited to, harassment related to an individual's race, color, religious creed, sex, national origin, ancestry, citizenship status, pregnancy, childbirth, physical disability, mental disability, age, military status or status as a Vietnam-era or special disabled veteran, marital status, registered domestic partner or civil union status, gender (including sex stereotyping and gender identity or expression), medical condition (including, but not limited to, cancer related or HIV/AIDS related), genetic information or sexual orientation is a violation of this policy and will be treated as a disciplinary matter. Your notification to the Company is essential to us. To report a complaint, contact the Administaff Anti-Harassment hotline number at 800-242-8893, ext. 3000 or 281-312-3000 in the Houston area.

The California Department of Fair Employment and Housing may also investigate and process complaints of harassment and discrimination. Violators may be subject to penalties and remedial measures that may include sanctions, fines, injunctions, reinstatement, back pay and damages. The addresses of the local offices of the Department of Fair Employment and Housing, which are subject to change, currently are as follows:

#### **Bakersfield:**

1001 Tower Way, Suite 250  
Bakersfield, CA 93309-1596

#### **Fresno:**

1320 East Shaw Avenue, Suite 150  
Fresno, CA 93710

#### **Los Angeles:**

611 West Sixth Street, Suite 1500  
Los Angeles, CA 90017

#### **Oakland:**

1515 Clay Street, Suite 701  
Oakland, CA 94612-2512

#### **Sacramento:**

2000 O Street, Suite 120  
Sacramento, CA 95814-5212

#### **San Diego:**

1350 Front Street, Suite 3005  
San Diego, CA 92101

#### **San Francisco:**

1515 Clay Street, Suite 701  
Oakland, CA 94612-2512

#### **San Jose:**

111 North Market Street, Suite 810  
San Jose, CA 95113-1102

#### **Santa Ana:**

2101 East 4th Street, Suite 255-B  
Santa Ana, CA 92705-3855

### **Massachusetts Employees Only**

The Massachusetts Commission Against Discrimination and/or the U.S. Equal Employment Opportunity Commission may also investigate and process complaints of harassment and discrimination. In Massachusetts, the Boston Office of the Massachusetts Commission Against Discrimination is located at One Ashburton Place, Room 601, Boston, MA 02108, and the U.S. Equal Employment Opportunity Commission is located at JFK Federal Building, Room 475, Boston, MA 02203.



## FAMILY AND MEDICAL LEAVE POLICY

*NOTE: This Policy supersedes and replaces all prior federal family and medical leave related policies, to the extent such policies exist, and is in effect only where the Client Company for which an employee works is a covered employer under applicable federal law. Additionally, application of this Policy is contingent upon the employee seeking leave benefits working for the Client Company at a worksite where fifty (50) or more employees are employed by Client Company within a 75-mile radius of that worksite.*

*Notwithstanding the above, an employee seeking leave benefits under this Policy must also satisfy all eligibility requirements as set forth below and required by applicable federal law. This Policy does not create any rights (contractual or otherwise) not already provided under federal, state or local law. Employees should, to the extent they wish to request and apply for family and medical related leave under any applicable federal or state law submit a Leave of Absence Request form to Administaff's Leave and Disability Group via fax at 800-233-1469.*

Under the Family and Medical Leave Act of 1993, as amended ("FMLA" or "the Act"), Client Company provides, as set forth below, unpaid family and medical leaves of absence to "eligible employees."

### Approved Reasons for Leave

FMLA leave may be taken for the following purposes:

1. the birth of an employee's child or to care for the newborn child;
2. the placement of a child with the employee for adoption or state-approved foster care;
3. the care of an employee's spouse, child, or parent ("family member") who has a serious health condition;
4. the employee's serious health condition which prevents the employee from performing any one essential function of the employee's position;
5. "qualifying exigency leave": the employee's responding or attending to a "qualifying exigency," as defined below per applicable law, arising out of a covered military member's covered active duty or notification of an impending call or order to covered active duty in the Armed Forces, National Guard or Reserves. A "covered military member" for purposes of this leave includes a spouse, son, daughter or parent of the employee; and
6. "covered servicemember leave": the employee's care of a "covered servicemember" who has incurred a serious illness or injury.
  - (a) A "covered servicemember" means a member of the Armed Forces, National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in out-patient status, or is on the temporary disability retired list for serious injury or illness. Here a "serious injury or illness" is defined as an injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank or rating.
  - (b) A "covered service member" also includes a veteran who was a member of the Armed Forces (including National Guard or Reserves) at any point in time within five (5) years preceding the date on which the veteran undergoes medical treatment. For purposes of veterans, a "serious injury or illness" is defined as an injury or illness that was incurred by the veteran in line of duty on active duty in the Armed Forces (or existed before the active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and "that manifested itself before or after the member became a veteran."

For purposes of family and medical leave, a "serious health condition" as set out in (3) and (4) above is defined as an illness, injury, impairment or physical or mental condition that involves either inpatient care or continuing treatment by a health care provider. Subject to certain conditions and applicable law, the continuing treatment requirement is met where an employee suffers an incapacity of more than three (3) consecutive, full calendar days and two (2) or more visits to a health care provider, or one (1) visit to a health care provider and a continuing regimen of care; an incapacity caused by pregnancy or prenatal care; a chronic condition, or permanent or long-term conditions; or absences due to multiple treatments. Other situations may meet the definition of continuing treatment. For purposes of this policy, "incapacity" means the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

For purposes of qualifying exigency leave, a "qualifying exigency" includes the following, provided the need for such leave arises out of the active duty or call to active duty status of a covered military member:

1. short-notice deployment where, if a covered military member is notified of an impending call or order to active duty in support of a contingency operation seven (7) or less calendar days prior to the date of deployment; leave based on this exigency is restricted to a total of seven (7) calendar days beginning on the applicable notification date;
2. military events and related activities sponsored by the military, including family support or assistance programs sponsored by the military, military service organizations or the American Red Cross;
3. childcare and school activities, where it is necessary to arrange for alternative childcare, provide childcare on an urgent or immediate need basis and not a routine or regular basis, enroll in or transfer to a new school or day care facility or attend meetings with school officials;
4. financial and legal arrangements to address the covered military member's absence;
5. counseling of eligible individuals by someone other than a health care provider, where the need for counseling is directly related to the active duty or call to active duty status of a covered military member;
6. rest and recuperation, for purposes of spending time with a covered military member where that individual is on short-term, temporary, rest and recuperation leave during the period of deployment; up to five (5) days of such leave may be taken for each instance of rest and recuperation;
7. post-deployment activities, including attendance at arrival ceremonies, reintegration briefings and events, and other programs sponsored by the military for a period of ninety (90) days following the termination of the covered military member's active duty and attending to issues that arise from the death of a covered military member; and
8. additional activities, provided that both the employee and Client Company agree that such activities constitutes a qualifying exigency and both agree to the timing and duration of the leave.

For purposes of covered servicemember leave, the employee seeking leave must be related to the covered servicemember as his/her spouse, son, daughter, parent or next of kin. "Next of kin," for purposes of this policy, is defined as the nearest blood relative of a covered servicemember, other than the covered servicemember's spouse, parent, son or daughter, in the following order of priority: blood relatives with legal custody, siblings, grandparents, aunts and uncles, and first cousins, and that person is needed to care for the covered servicemember. A veteran is "a person who served in the

active military, Naval, or Air Service, and who was discharged or released therefrom under conditions other than dishonorable.”

### Eligible Employee

An active full-time or part-time employee is eligible for FMLA leave under any of the above leave categories provided that on the date the employee's leave is to commence:

1. The employee works at a Client Company worksite where fifty (50) or more employees are employed by Client Company within a 75-mile radius of that worksite;
2. The employee has been employed by Client Company for at least twelve (12) months in the preceding seven (7) years (limited exceptions apply to the 7-year requirement); and
3. The employee has worked 1,250 hours during the 12-month period immediately preceding the commencement of leave.

In determining FMLA eligibility, an employee re-employed following military service will be given credit for (i) the period of uniformed service towards the months-of-employment eligibility requirement, and (ii) the hours of service that would have been performed but for the period of uniformed service.

### Length of Family and Medical Leave and Qualifying Exigency Leave

An eligible employee is entitled to a combined total of twelve (12) workweeks of unpaid leave within a 12-month period. The amount of leave available to an employee will be calculated by looking backward at the amount of leave taken within the 12-month period immediately preceding the first date of leave. Leave taken for the care of a newborn child or placement for adoption or foster care must be taken within twelve (12) months of the birth or placement of the child, and it must also be taken as an uninterrupted, continuous leave of absence unless the Client Company allows intermittent leave or a reduced schedule for these reasons.

If both a husband and wife are employed by Client Company, and are eligible for leave, except for leave due to the serious health condition of the employee or employee's child, the two may take a combined total of twelve (12) weeks.

Intermittent leave or a reduced schedule may be approved for the employee's serious health condition or a family member's serious health condition where medically necessary and where the need for such leave is best accommodated through such scheduling. Intermittent leave or a reduced scheduled leave is also available for qualifying exigency leave. An employee requesting intermittent leave/reduced schedule may be transferred temporarily to an available alternative position with equivalent pay and benefits, or to a part-time position with an equivalent hourly rate and benefits, if such a position better accommodates the need for intermittent leave/reduced schedule.

These types of leave run concurrent with other leave entitlements provided under federal, state, and local law to the extent covered and permitted by those laws.

### Length of Covered Servicemember Leave

An eligible employee is entitled to a combined total of twenty-six (26) workweeks of unpaid leave within a single 12-month period for covered servicemember leave. Leave to care for an injured or ill servicemember, whether or not combined with other FMLA-qualifying leave, may not exceed twenty-six (26) weeks in a single 12-month period. In that single 12-month period, the employee is entitled to no more than twelve (12) weeks of leave for any of the other types of FMLA leaves. If both a husband and wife are employed by Client Company, and are eligible for covered servicemember leave, the two may take a combined total of twenty-six (26) weeks. Intermittent leave or a reduced schedule may be approved for covered servicemember leave where medically necessary and where the need for such leave is best accommodated through such scheduling. An employee requesting intermittent leave/reduced schedule leave may be transferred temporarily to an available alternative position

with equivalent pay and benefits, or to a part-time position with an equivalent hourly rate and benefits, if such a position better accommodates the need for intermittent leave/reduced schedule leave.

Covered servicemember leave runs concurrent with other leave entitlements provided under federal, state and local law to the extent covered and permitted by those laws.

### Substitution of Paid Leave

An employee taking family and medical leave due to the employee's own serious health condition must substitute all accrued and unused sick leave, paid vacation, personal leave, paid time off and, if applicable, short-term salary continuation (the preceding collectively referred to hereafter as “accrued paid leave”) before continuing leave on an unpaid basis. Where an employee receives disability benefits pursuant to a disability benefit plan, however, the substitution of the employee's accrued paid leave is not required and does not apply because the employee is getting paid. Where permissible under state law and as permitted by applicable disability plan rules, an employee may, with the approval of Client Company, choose to supplement disability plan benefits with accrued paid leave. Where permissible under state workers' compensation laws, an employee may, with the approval of Client Company, choose to supplement workers' compensation benefits with accrued paid leave.

An employee taking leave for reasons other than an employee's own serious health condition must exhaust all accrued unused paid vacation, personal leave and paid time off before continuing leave on an unpaid basis. Any family and medical leave, qualifying exigency leave, whether paid, unpaid or a combination thereof, will be counted toward the 12-week leave entitlement. Any covered servicemember leave, whether paid, unpaid, or a combination thereof, either taken by itself or together with any other family and medical leave and/or qualifying exigency leave, whether paid, unpaid or a combination thereof, will be counted toward the 26-week leave entitlement.

### Employee Notification Requirements

If an employee expects to take family and medical leave, qualifying exigency leave or covered servicemember leave, the employee must notify the Administaff Leave and Disability Group of the intention to take leave at least thirty (30) days in advance of the expected leave by completing a Leave of Absence Request form. If the need for leave is not foreseeable, the employee must provide notification of leave to the Administaff Leave and Disability Group as soon as is practicable under the circumstances and in compliance with Client Company's established absenteeism and tardiness policies, or other like policies, with violation of the same resulting in possible disciplinary action, up to and including termination.

### Medical Certification

An employee who takes leave for the employee's serious health condition, to care for a family member with a serious health condition, or to care for a covered servicemember, must submit to the Administaff Leave and Disability Group written medical certification of the need for such leave from the applicable health care provider within fifteen (15) calendar days of the request to provide the certification. An employee seeking such leave will be asked to submit a certification form detailing the reason(s) for the leave. If the employee fails to do so, the Client Company may delay the commencement of the requested leave, withdraw any designation of the requested leave as FMLA leave, or deny the requested leave, and time taken off by the employee would be subject to Client Company's established absenteeism and tardiness policies, or other like policies, with violation of the same resulting in possible disciplinary action up to and including termination.

If an employee's medical certification is incomplete and/or insufficient, Administaff may notify an employee in writing as to what is incomplete and/or insufficient and what is necessary to make the certification complete. The employee will then have seven (7) calendar days to cure any noted deficiencies by resubmitting the

medical certification. Failure to ultimately provide a complete and sufficient certification may result in the denial of the requested FMLA leave. Where an employee has first been given the opportunity to cure a medical certification deficiency or deficiencies, Administaff may subsequently, through either a human resources professional or leave administrator, contact the employee's health care provider directly to clarify and authenticate the certification.

The Client Company, where it has reason to doubt the validity of a medical certification, may request a second or third medical opinion at its expense for verification of an employee's serious health condition. The opinion of the third health care provider, who is approved jointly by Client Company and the employee, shall be final and binding on Client Company and the employee; provided, however, pending receipt of the second (or third) medical opinion, the employee is provisionally entitled to leave sought under this Policy. If the certifications do not ultimately establish the employee's entitlement to FMLA leave, the leave shall not be designated as FMLA leave and the time off taken by the employee will be subject to the Client Company's absenteeism and tardiness policies or other like policies, with violation of the same resulting in possible disciplinary action up to and including termination. In addition, while the employee is on leave, the Client Company may require the employee to provide recertification(s) of the employee's medical condition and may inquire as to the employee's intentions to return to work.

An employee on uninterrupted, continuous leave due to the employee's own serious health condition will be required to provide a job-related medical certification of fitness before the employee is allowed to return to work. Likewise, for intermittent leave situations where reasonable job safety concerns exist, a fitness-for-duty certification may be requested before an employee may return to work. Failure to provide any such applicable certification may result in the delay or denial of job restoration.

Where an employee is on FMLA leave and is unable to return to work because of the continuation, recurrence or onset of the serious health condition of either the employee or the employee's family member, including a serious illness or injury suffered by a covered servicemember, the employee will be required to provide a certification issued by the applicable health care provider.

### **"Qualifying Exigency" Leave Certification**

An employee who takes a qualifying exigency leave must submit to the Administaff Leave and Disability Group written certification of an impending call or order to covered active duty within fifteen (15) calendar days of the request to provide the certification. An employee seeking such leave will be asked to submit a certification form detailing the reason(s) for the leave. An employee may also be required to submit appropriate supporting documentation in the form of a copy of the covered military member's active duty orders or other military documentation indicating the appropriate military status and the dates of active duty status. Failure to supply the requested certification or other papers may result in a delay or denial of the requested leave, and time off taken by the employee will be subject to the Client Company's absenteeism and tardiness policies or other like policies, with violation of the same resulting in possible disciplinary action up to and including termination.

### **Benefits Continuation**

The same health care benefits coverage provided to an employee on the day prior to taking family and medical leave will be maintained for up to the twelve (12) weeks required for family and medical leave and qualifying exigency leave, or up to the twenty-six (26) weeks required for covered servicemember leave, or as required by law, provided the employee continues to pay any required contribution for benefits. Employees who are on leave are responsible for making their periodic payment of the required contribution to Administaff at the following address.

Administaff  
Attn: Premium Funding Group MC 3-2700  
19001 Crescent Springs Drive  
Kingwood, Texas 77339-3802

Upon exhaustion of the applicable twelve (12) or twenty-six (26) workweeks of leave granted under this policy or if an employee fails to return to work at the end of the leave, a loss of coverage will occur, and continuation of health care coverage would be offered through COBRA. An employee who does not return from leave may be required, under certain circumstances provided by the Act, to reimburse Administaff for any employee contributions paid by Administaff or the Client Company while the employee was on unpaid leave.

While on leave, an employee must continue to pay the employee's contributions or loan payments for any applicable benefits which would otherwise be automatically deducted from the employee's wages (e.g., supplemental life insurance, credit union loans, 401(k) loans). Contact the Administaff Contact Center at 866-715-3552 for details regarding employee contributions. For questions regarding 401(k) loan payments, please contact Administaff Retirement Services at 888-401-5273.

The period of time an employee is on family and medical leave will be treated as continued service for purposes of vesting and eligibility to participate under any available pension or retirement plan, if applicable. Absences due to leave will not be counted as time worked for the purpose of seniority or computing vacation, sick leave or personal days.

### **Job Restoration**

An employee will normally be returned to the same or an equivalent position when the employee returns from family and medical leave, qualifying exigency duty leave or covered servicemember leave, with no loss of benefits accrued prior to leave. An employee who does not return to work at the end of an authorized leave is subject to termination of employment. In the event an employee's position with Client Company is affected by a decision or event not related to the employee's leave of absence, e.g., job elimination due to a reduction in force, the employee will be affected to the same extent as if he was not on leave.

Certain "key employees" as defined under the FMLA may not be eligible to be restored to the same or an equivalent position after leave if doing so would cause substantial and grievous economic injury to the operations of the assigned company. Administaff will notify such employees of their "key employee" status and the conditions under which job restoration will be denied, if applicable.

### **Workers' Compensation and Family and Medical Leave**

If an employee is eligible for FMLA, an absence related to a workers' compensation injury is counted against an employee's family and medical leave entitlement where the workers' compensation injury meets the definition herein of a "serious health condition." An employee who has provided a workers' compensation form from the employee's treating physician may be asked to also provide a medical certification form to determine whether the employee's workers' compensation injury also meets the definition of a "serious health condition."

### **Questions About Family and Medical Leave**

*If you have any questions about your rights or responsibilities under this policy, contact the Administaff Contact Center at 866-715-3552 (select "Benefits"), accessible weekdays between 7 a.m. and 7 p.m. Central time.*

Client Company and Administaff will, as such respective related duties and responsibilities are set forth under the Act, comply with all applicable federal, state and local laws in administering this Policy.





## EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

### Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

### Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

### Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

### Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

### Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

### Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

### Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

### Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

### Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

### Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

### Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.**



For additional information:  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
[WWW.WAGEHOUR.DOL.GOV](http://WWW.WAGEHOUR.DOL.GOV)



## **REQUIRED FORMS SECTION**

### **RETURNING YOUR FORMS TO ADMINISTAFF**

## **Where Do I Submit the Forms?**

**First, remove the policies from the front of this booklet and retain for your records.**

### ***During a new client orientation session:***

Immediately submit the completed Forms & Policies booklet to the Administaff orientation representative.

### ***All other new hires:***

Immediately submit the completed Forms & Policies booklet to your supervisor, who will forward them to your Administaff payroll specialist.

### ***Questions?***

Contact your Administaff payroll specialist or the Administaff Contact Center at 866-715-3552. You can find all your contacts within the Contact Us section on [www.administaffservices.com](http://www.administaffservices.com).

**Employee Instructions:**

- Complete the Employee Identification section and forward to your supervisor. *Any information relating to race, ethnicity and gender is collected to comply with federal regulations, which require certain recordkeeping and reporting requirements. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment.*

**Supervisor Instructions:**

- Complete all of page 2 and the Employee Race/Ethnicity section on page 1 by visual observation if employee does not self-identify.
- Submit the completed form. **Clients:** to your Administaff payroll specialist  
or **Administaff Corporate:** to Corporate Human Resources, MC 1-2200
- Contact your Administaff payroll specialist with any questions regarding this form.

EMPLOYEE IDENTIFICATION – Send this form to your supervisor when completed.

<b>Do you ever travel outside the United States for work-related purposes?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes: Destination Country _____ Duration _____ If Yes, please complete the destination country and average duration spent on foreign travel per trip.				
Social Security Number		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
First Name – All names per your Social Security Card		Middle Name	Last Name	
Home Mailing Address		City	State	ZIP Code
County of Home Address <b>U.S.A.</b>		Date of Birth (mm/dd/yyyy)		
Home Phone Number (      )		Home Fax Number (      )	Home Cell Number (      )	
Home E-mail Address				
Work Phone Number (      )	Work Extension	Work Fax Number (      )	Work Cell Number (      )	
Work E-mail Address				
Race/Ethnicity (Check ONE) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White (not Hispanic or Latino) <input type="checkbox"/> Black or African American (not Hispanic or Latino) <input type="checkbox"/> Native Hawaiian or other Pacific Islander (not Hispanic or Latino) <input type="checkbox"/> Asian (not Hispanic or Latino) <input type="checkbox"/> American Indian or Alaskan Native (not Hispanic or Latino) <input type="checkbox"/> Two or more races (not Hispanic or Latino)				
Emergency Contact First Name		Emergency Contact Last Name		Relationship to Employee
Emergency Contact Street Address			State	ZIP Code
Emergency Contact City	Country	Work Telephone Number (      )	Home Telephone Number (      )	

**CLIENT INFORMATION**

Client Name	Client Number
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**Note:** Go to page 2 of this form and enter your name and Social Security number at the top of the page.  
Send this form to your supervisor.







Employee First Name	Employee Last Name	Social Security Number
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SUPERVISOR – Submit the completed form.

**Clients:** to your Administaff payroll specialist

or **Administaff Corporate:** to Corporate Human Resources, MC 1-2200

<b>Is this employee an owner, partner, or corporate executive officer listed by title in corporate charter or by-laws?</b> <b>Note:</b> Executive/Senior Level Official and Manager box must be checked in Job Category section below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, check ONE of the following: <input type="checkbox"/> Job duties are clerical or inside sales. <input type="checkbox"/> Job duties are outside sales. <input type="checkbox"/> Job duties are <u>not</u> clerical or sales.
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<b>Employee Job Category – Check only one.</b>		
<input type="checkbox"/> <b>Executive/Senior Level Official and Manager</b> Plans, directs and formulates policies, sets strategy and provides overall direction of organizations. <b>Examples:</b> Chief executive officer, chief operating officer, president or executive vice president of functional areas or operating groups.  <input type="checkbox"/> <b>First/Mid Level Official and Manager</b> Receives direction from executive/senior level management and implements policies, programs and directives of executive/senior management or reports directly to middle managers and oversees day-to-day operational objectives, directly supervising activities of exempt and non-exempt personnel. <b>Examples:</b> Vice president, director, controller, treasurer, human resources, information systems, marketing or operations manager, first-line manager, branch manager.  <input type="checkbox"/> <b>Professional</b> Requires a college degree or professional certification. <b>Examples:</b> Architect, accountant, lawyer, teacher, engineer, computer programmer.	<input type="checkbox"/> <b>Technician</b> Requires the application of scientific skills, usually obtained by post-secondary education, which may include training certification or comparable experience. <b>Examples:</b> Drafter, engineering aide, technical illustrator, medical technician.  <input type="checkbox"/> <b>Sales Worker</b> Primarily engages in direct sales in a non-managerial capacity. <b>Examples:</b> Sales representative, cashier, real estate agent and broker.  <input type="checkbox"/> <b>Administrative Support Worker</b> Provides administrative and support assistance, primarily in office settings. <b>Examples:</b> Legal assistant, bookkeeper, office or administrative assistant, secretary, computer operator, shipping and receiving clerk.  <input type="checkbox"/> <b>Craft Worker</b> Engages in a higher-skilled occupation, such as construction and natural resource extraction or the installation and maintenance of equipment and machines. <b>Examples:</b> Building trade, hourly paid supervisor and lead operator, mechanic, skilled machinist, electrician and painter, earth driller, derrick operator, engraver, millwright.	<input type="checkbox"/> <b>Operative</b> Engages in an intermediate skilled occupation such as operating machines or factory-related processing equipment. <b>Examples:</b> Workers at textile machines, photographic processes, assembly plants or food processing, baker, driver, sailor, hand packer.  <input type="checkbox"/> <b>Laborer and Helper</b> Engages in limited-skill work that requires brief training in order to perform the essential tasks of the job, demanding little independent judgment. <b>Examples:</b> Construction worker, garage laborer, car washer, groundskeeper.  <input type="checkbox"/> <b>Service Worker</b> Engages in service-related work that requires skills that may be acquired through formal training, job-related training or direct experience. <b>Examples:</b> Personal service attendant, nurse's aide or orderly, cleaner, cook, firefighter, guard, doorkeeper.

<b>Employee Employment Information</b>									
Job Title			Job Function				Benefit Class		
Billing Group		Hire Date with Administaff		Workers' Comp Code for Worksite State			Is this employee exempt from overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Physical Address	Street Address			City	County	State	ZIP	Address Code → Administaff Use Only →	
Worksite where employee works									
Check Delivery where employee's check is delivered									
Reporting where employee's supervisor is located									
Worksite Location is (check one): <input type="checkbox"/> Actual Client Location <input type="checkbox"/> Offsite Location <input type="checkbox"/> Employee's Home									
Print Supervisor Name									
Classification: <input type="checkbox"/> Full time (≥ 30 hours) <input type="checkbox"/> Part time (< 30 hours) <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal					Pay Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Monthly				
Pay Rate 1 <input type="checkbox"/> Hourly \$ _____ / hr. <input type="checkbox"/> Salary \$ _____ / yr. <input type="checkbox"/> Commission Draw: <input type="checkbox"/> No <input type="checkbox"/> Yes, amount \$ _____					Pay Rate 2 _____ / hr. <input type="checkbox"/> Hourly \$ _____ / hr. <input type="checkbox"/> Salary \$ _____ / pay period <input type="checkbox"/> Commission Draw: <input type="checkbox"/> No <input type="checkbox"/> Yes, amount \$ _____				
Pay Rate 3 _____ / hr. <input type="checkbox"/> Hourly \$ _____ / hr. <input type="checkbox"/> Salary \$ _____ / pay period <input type="checkbox"/> Commission Draw: <input type="checkbox"/> No <input type="checkbox"/> Yes, amount \$ _____					Is this employee: Part of a collective bargaining unit or union? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Paid via tips? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Paid via piece work? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No Does this employee supervise people? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
Department			Location			Client Original Hire Date			



# Form W-4 (2010)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: <div style="display: inline-block; vertical-align: middle;"><div style="display: inline-block; vertical-align: middle;">• You are single and have only one job; or</div><div style="display: inline-block; vertical-align: middle;">• You are married, have only one job, and your spouse does not work; or</div><div style="display: inline-block; vertical-align: middle;">• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</div></div> . . . . .	<b>B</b> _____
<b>C</b>	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$1,800 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .	<b>F</b> _____
<b>(Note.</b> Do <b>not</b> include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)		
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <div style="margin-left: 20px;">• If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have three or more eligible children.</div> <div style="margin-left: 20px;">• If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" <b>additional</b> if you have six or more eligible children.</div>	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. <b>(Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b> _____
	For accuracy, <b>complete all worksheets that apply.</b> <div style="display: inline-block; vertical-align: middle;"><div style="display: inline-block; vertical-align: middle;">• If you plan to <b>itemize or claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</div><div style="display: inline-block; vertical-align: middle;">• If you have <b>more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</div><div style="display: inline-block; vertical-align: middle;">• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</div></div>	

Cut here and give Form W-4 to your employer. Keep the top part for your records.

<b>Form W-4</b>		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074
Department of the Treasury Internal Revenue Service		<b>2010</b>		
▶ <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>				
1 Type or print your first name and middle initial. Last name		2 Your social security number		
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5		
6 Additional amount, if any, you want withheld from each paycheck		6		\$
7 I claim exemption from withholding for 2010, and I certify that I meet <b>both</b> of the following conditions for exemption. <div style="margin-left: 20px;">• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b></div> <div style="margin-left: 20px;">• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</div> <div style="margin-left: 20px;">If you meet both conditions, write "Exempt" here . . . . . ▶</div>				
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (Form is not valid unless you sign it.) ▶				
Date ▶				
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)
Administaff, 19001 Crescent Springs Drive, Kingwood, Texas 77339-3802				
For Privacy Act and Paperwork Reduction Act Notice, see page 2.				



**Deductions and Adjustments Worksheet****Note.** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

- 1** Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions . . . . . **1** \$ \_\_\_\_\_
- 2** Enter:  $\left\{ \begin{array}{l} \$11,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,400 \text{ if head of household} \\ \$5,700 \text{ if single or married filing separately} \end{array} \right\}$  . . . . . **2** \$ \_\_\_\_\_
- 3** **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . **3** \$ \_\_\_\_\_
- 4** Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919) . . . . . **4** \$ \_\_\_\_\_
- 5** **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 6* in Pub. 919.) . . . . . **5** \$ \_\_\_\_\_
- 6** Enter an estimate of your 2010 nonwage income (such as dividends or interest) . . . . . **6** \$ \_\_\_\_\_
- 7** **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . **7** \$ \_\_\_\_\_
- 8** **Divide** the amount on line 7 by \$3,650 and enter the result here. Drop any fraction . . . . . **8** \_\_\_\_\_
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, page 1 . . . . . **9** \_\_\_\_\_
- 10** **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** \_\_\_\_\_

**Two-Earners/Multiple Jobs Worksheet** (See *Two earners or multiple jobs* on page 1.)**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1** Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** \_\_\_\_\_
- 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3." . . . . . **2** \_\_\_\_\_
- 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** \_\_\_\_\_
- Note.** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4–9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.
- 4** Enter the number from line 2 of this worksheet . . . . . **4** \_\_\_\_\_
- 5** Enter the number from line 1 of this worksheet . . . . . **5** \_\_\_\_\_
- 6** **Subtract** line 5 from line 4 . . . . . **6** \_\_\_\_\_
- 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** \$ \_\_\_\_\_
- 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . **8** \$ \_\_\_\_\_
- 9** Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** \$ \_\_\_\_\_

**Table 1****Table 2**

Married Filing Jointly				All Others			
If wages from <b>LOWEST</b> paying job are—		Enter on line 2 above		If wages from <b>LOWEST</b> paying job are—		Enter on line 2 above	
\$0 - \$7,000 -		0		\$0 - \$6,000 -		0	
7,001 - 10,000 -		1		6,001 - 12,000 -		1	
10,001 - 16,000 -		2		12,001 - 19,000 -		2	
16,001 - 22,000 -		3		19,001 - 26,000 -		3	
22,001 - 27,000 -		4		26,001 - 35,000 -		4	
27,001 - 35,000 -		5		35,001 - 50,000 -		5	
35,001 - 44,000 -		6		50,001 - 65,000 -		6	
44,001 - 50,000 -		7		65,001 - 80,000 -		7	
50,001 - 55,000 -		8		80,001 - 90,000 -		8	
55,001 - 65,000 -		9		90,001 - 120,000 -		9	
65,001 - 72,000 -		10		120,001 and over		10	
72,001 - 85,000 -		11					
85,001 - 105,000 -		12					
105,001 - 115,000 -		13					
115,001 - 130,000 -		14					
130,001 - and over		15					

Married Filing Jointly		All Others	
If wages from <b>HIGHEST</b> paying job are—		Enter on line 7 above	
\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



**Form I-9, Employment  
Eligibility Verification**Department of Homeland Security  
U.S. Citizenship and Immigration Services**Instructions****Read all instructions carefully before completing this form.**

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

**What Is the Purpose of This Form?**

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

**When Should Form I-9 Be Used?**

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

**Filling Out Form I-9****Section 1, Employee**

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Noncitizen nationals of the United States** are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

**Employers should note** the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

**Preparer/Translator Certification**

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

**Section 2, Employer**

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

**Employers must record in Section 2:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

**For more detailed information, you may refer to the *USCIS Handbook for Employers (Form M-274)*. You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."**

### Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A.** If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B.** If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C.** If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:
  - 1.** Examine any document that reflects the employee is authorized to work in the United States (see List **A or C**);
  - 2.** Record the document title, document number, and expiration date (if any) in Block C; and
  - 3.** Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3**.

### What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

### USCIS Forms and Information

To order USCIS forms, you can download them from our website at [www.uscis.gov/forms](http://www.uscis.gov/forms) or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at [www.uscis.gov](http://www.uscis.gov) or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at [www.uscis.gov/e-verify](http://www.uscis.gov/e-verify) or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at [www.uscis.gov](http://www.uscis.gov).

### Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

### Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

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## Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**





Department of Homeland Security  
U.S. Citizenship and Immigration Services

# Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

## Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

**I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.**

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) \_\_\_\_\_
- ☐ An alien authorized to work (Alien # or Admission #) \_\_\_\_\_ until (expiration date, if applicable - month/day/year)

Employee's Signature

Date (month/day/year)

**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature

Print Name

Address (Street Name and Number, City, State, Zip Code)

Date (month/day/year)

**Section 2. Employer Review and Verification** (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____				

**CERTIFICATION:** I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) Administaff, 19001 Crescent Springs Drive, Kingwood, Texas 77339-3802		Date (month/day/year)

## Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: \_\_\_\_\_ Document #: \_\_\_\_\_ Expiration Date (if any): \_\_\_\_\_

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
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## LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

### LIST A

**Documents that Establish Both  
Identity and Employment  
Authorization**

### LIST B

**Documents that Establish  
Identity**

### LIST C

**Documents that Establish  
Employment Authorization**

OR

AND

1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
	4. Voter's registration card	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	5. U.S. Military card or draft record	
	6. Military dependent's ID card	
	7. U.S. Coast Guard Merchant Mariner Card	5. Native American tribal document
	8. Native American tribal document	
	9. Driver's license issued by a Canadian government authority	6. U.S. Citizen ID Card (Form I-197)
	<b>For persons under age 18 who are unable to present a document listed above:</b>	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**

Client Number (Optional)	Last 4 Digits of SSN
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This Agreement is between **ADMINISTAFF COMPANIES II, L.P.** ("Administaff"), and \_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name Last Name (All Names per Social Security Card) ("Employee") pursuant to a Client Service Agreement

between Administaff and \_\_\_\_\_ ("Client Company") in which Client Company and Administaff have agreed to a co-employment relationship. This Agreement deals only with Employee's employment with Administaff. Termination of this Agreement may not necessarily terminate Employee's employment with Client Company.

1. Employee agrees to perform such duties as shall be determined by Client Company and communicated to Employee by and through an on-site supervisor or designee and notwithstanding any such changes, the employment of Employee shall be construed as continuing under this Agreement, as modified. Pursuant to the co-employment relationship with Client Company, Employee understands and agrees that Administaff reserves a right of direction and control over Employee, including a right to hire or terminate, and a right to resolve workplace disputes not subject to a collective bargaining agreement. However, Administaff does not maintain a right to make decisions or give direction with regard to the products produced or services provided by the Client Company to its customers.

2. **AT-WILL EMPLOYMENT.** Employee agrees that Employee's employment by and payment of compensation through Administaff can be terminated, with or without cause, and without notice, at any time, at the option of either Administaff or Employee. Employee understands that no on-site supervisor or Administaff representative, other than the President or a Senior Vice President of Administaff, has authority to enter into an agreement for employment with Administaff for any specific period of time, or to make any agreement contrary to the foregoing. Any such agreement must be in writing.

3. **ADDITIONAL PAYMENTS.** Employee agrees that Client Company is solely obligated for administering and paying all Client Company-initiated programs, policies and practices including, but not limited to, vacation, sick time, paid time off, paid leaves of absence, severance, bonus, commissions, stock option grants or deferred compensation plans (the "Additional Payments") even though the Additional Payments may be processed through Administaff. This provision does not in itself establish any such program, policy or practice, or create a right in them. Employee acknowledges that Administaff will not provide to Employee, and has no policy providing to workers similarly situated to Employee, benefits or payments such as the Additional Payments. To the extent the Additional Payments are paid through Administaff's payroll to Employee, it is solely as a payroll service for Client Company. Employee hereby authorizes Administaff to deduct employee's contributions under any 401k plan, including an automatic enrollment plan, from employee's wages. Employee acknowledges and agrees that the Client Company has sole legal responsibility and liability for compliance with certain laws and regulations including, but not limited to, the Worker Adjustment and Retraining Notification Act ("WARN"), Fair Labor Standards Act ("FLSA") (including but not limited to properly classifying employees as exempt/nonexempt for overtime purposes and liability for unpaid overtime), Equal Pay Act, Uniformed Services Employment and Reemployment Rights Act ("USERRA"), Family and Medical Leave Act ("FMLA") and any state or local equivalent of any of the foregoing.

4. **NOTICE OF WORKERS' COMPENSATION INSURANCE COVERAGE.** Administaff maintains workers' compensation insurance coverage for Employee. In the event of an injury in the workplace, Employee agrees that Employee's sole remedy against Administaff and/or Client Company lies in coverage under Administaff's workers' compensation insurance.

5. **EFFECTIVE DATE.** This Agreement and the Employee's beginning date of employment are not effective until after the first payroll for Client Company has been paid by Administaff and includes the Employee listed hereinabove. The Employee's effective date of employment will be established retroactive to the first day of work for which Employee is paid by Administaff in that payroll.

6. **NOTICE OF COMPLAINT.** Administaff believes that the work environment should be free of discrimination and harassment and that the Employee has a means to discuss any complaint. Employee agrees that Employee will read and abide by Administaff's Anti-Harassment Policy found in the Employee Service Center at [www.administaffservices.com](http://www.administaffservices.com), and will promptly report any such alleged incident or problem to Employee's supervisor. As stated in the policy, if Employee believes it would be inappropriate to report the incident to Employee's supervisor, or if the problem is not addressed adequately by the supervisor, Employee agrees to promptly contact the Administaff Human Resources Services Department at 877-348-2431 or 281-312-3000. Employee also should contact the Administaff Human Resources Services Department regarding any complaint or concern Employee may have regarding any Administaff policy or Employee's co-employment with Administaff.

7. **POLICIES.** Employee agrees to abide by all Administaff policies made known to Employee.



Client Number (Optional)	Last 4 Digits of SSN
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8. **BENEFITS.** Nothing in this Agreement creates any right to participate in any Administaff employee benefit plan. All such eligibility is controlled by each plan and applicable law.

9. **ASSIGNMENT.** In the event Client Company files bankruptcy and Administaff is required to pay an amount to Employee that would otherwise have been due from Client Company, Employee hereby assigns all rights that Employee has as an employee of Client Company to Administaff for any such amounts paid. In consideration for this assignment, Administaff agrees to compensate Employee an additional five percent (5%) premium on the amounts actually recovered by Administaff from Client Company through the bankruptcy assignment by Employee. It is expressly understood that the maximum premium Employee could receive under this paragraph is 5% of the amounts Administaff actually paid to Employee for which Employee made assignment under this paragraph.

10. **ENTIRE AGREEMENT.** This Agreement supersedes any and all other Agreements between Administaff and Employee, either oral or in writing, with respect to the employment of Employee by Administaff and contains all the covenants and Agreements between the parties with respect to such employment in any manner whatsoever and in no way creates or alters any separate agreement Client Company may have with Employee.

11. **FOREIGN DUTY ASSIGNMENT.** If Employee is sent to work in any foreign country, Employee must contact the payroll specialist at Administaff, whose contact information can be located on the Employee Service Center at [www.administaffservices.com](http://www.administaffservices.com), to advise of Employee's new work location. This is necessary for several reasons, including that a foreign location may impact workers' compensation or other insurance coverage.

12. **SEVERABILITY.** If any term or provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions of this Agreement shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

13. **WAIVER.** The failure of either party to require performance of any provision of this Agreement at any time, or on more than one occasion, shall not affect the right of either party, at a later time, to enforce that provision or any other term or provision of this Agreement.

This Agreement will not be accepted by Administaff if there are any changes made to it unless the changes are prepared by Administaff.

CO-EMPLOYER  
**ADMINISTAFF COMPANIES II, L.P.**  
 by: Administaff Companies, Inc.,  
 its General Partner

EMPLOYEE



Employee's Signature

Date Signed

19001 Crescent Springs Drive  
 Kingwood, Texas 77339-3801  
 Tel: 800-237-3170

Printed Name Per Social Security Card

Last 4 Digits of  
 Social Security  
 Number

**RETURN THE COMPLETED, DATED AND SIGNED FORM  
 TO YOUR ADMINISTAFF PAYROLL SPECIALIST.**





**Completion Instructions**

- Complete all employee information.
- Read all appropriate acknowledgment of receipts.
- Send the completed and signed form to your Administaff payroll specialist with the rest of your completed employment forms.
- By completing this form you are acknowledging receipt of all applicable policies.
- For additional information, contact your Administaff human resources specialist or payroll specialist.

**EMPLOYEE INFORMATION** - Complete all fields.

Employee Name	Last 4 Digits of Social Security Number
Client Company Name	Client Number

**ANTI-HARASSMENT POLICY ACKNOWLEDGMENT OF RECEIPT  
(Rev. 04-01-10)**

I have received a copy of the Company's Anti-Harassment Policy (for the purposes of this policy, "Company" means Administaff and the Client Company.)

I understand it is my responsibility to carefully read the policy and become familiar with its contents. If I have any questions or need to report a complaint, I will bring my concerns to the attention of both my supervisor, manager or owner of Client Company and the Anti-Harassment hotline number at 800-242-8893, ext. 3000 or 281-312-3000 in the Houston area.

**DRUG-FREE WORKPLACE POLICY ACKNOWLEDGMENT OF RECEIPT  
(For Texas Employees Only)  
(Rev. 04-01-09)**

I have received a copy of the Company's Drug-Free Workplace Policy (for the purposes of this policy, "Company" means Administaff and the Client Company).

I understand it is my responsibility to carefully read the policy and become familiar with its contents.

I understand the policy and accept its provisions as terms and conditions of my employment with the Company. I further understand that violations of the policy could result in termination of my employment, and, therefore, I agree to abide by the terms of this policy.

**FAMILY AND MEDICAL LEAVE POLICY ACKNOWLEDGMENT OF RECEIPT  
(Rev. 12-01-09)**

I have received a copy of the Client Company's Family and Medical Leave Policy.

If I have any questions about my rights or responsibilities under this policy, I will contact the Administaff Contact Center at 866-715-3552 (select "Benefits"), accessible weekdays between 7 a.m. and 7 p.m. Central time.

**SIGN AND DATE THE FORM**

Employee Signature	Date Signed
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## OPTIONAL FORMS SECTION

These forms are optional and dependent upon your organization's requirements. If a Direct Deposit alternative has been set up by your company, you may elect to use or cancel this service at any time during your employment. The Deduction Authorization form may need to be completed for certain pay deductions.

### RETURNING YOUR FORMS TO ADMINISTAFF

## Where Do I Submit the Forms?

**First, remove the policies from the front of this booklet and retain for your records.**

***During a new client orientation session:***

Immediately submit the completed Forms & Policies booklet to the Administaff orientation representative.

***All other new hires:***

Immediately submit the completed Forms & Policies booklet to your supervisor, who will forward them to your Administaff payroll specialist.

***Questions?***

Contact your Administaff payroll specialist or call the Administaff Contact Center at 866-715-3552. You can find all your contacts within the Contact Us section on **[www.administaffservices.com](http://www.administaffservices.com)**.

**General Instructions: Frequently Asked Questions****Q. I want to enroll in direct deposit for the first time. What do I do?**

1. Check the "New" box to enroll in direct deposit for the first time.
2. Select the block designated as "Balance Account" for your main direct deposit account and indicate whether your "entire check" or the "Balance" is to be direct deposited into that account.

**Note:** If you choose "Balance", additional accounts need to be indicated. For each additional account, indicate a dollar amount per paycheck to be direct deposited.

**Q. How many accounts can I assign direct deposit?**

You can have up to four accounts for direct deposit.

**Q. May I use direct deposit and receive part of my pay in a check?**

Your entire paycheck must be direct deposited into the account(s) specified. You may **NOT** have a portion of your check direct deposited and still receive the balance in a physical, negotiable paycheck.

**Q. If I have more than one account selected, do I have to select Balance as one of my direct deposit selections?**

If more than one account is listed, one account **must** be assigned as Balance and the other accounts must have specific dollar amounts indicated. The Balance account will receive the balance of your paycheck after the specific dollar amount(s) have been deposited into your other account(s).

**Q. Should I verify my account and routing numbers with my financial institution?**

You **must** verify account and routing numbers with your financial institution because not all checks and/or deposit slips contain this information. Administaff is not responsible for errors or processing delays caused by incorrect or missing information.

**Q. I am currently receiving direct deposit but I want to add another account. What do I do?**

Check "Add" to add a financial institution and/or account for direct deposit. Complete an "Additional Account" block for each account to be added. You must provide the financial institution name and financial institution phone number for verification of information for each account added.

**Note:** If you currently have four direct deposit accounts established, you must cancel an existing account before adding a new one.

**Q. I want to cancel a direct deposit account. What do I do?**

Complete and submit the Direct Deposit with ePayStub Cancellation Request to your Administaff payroll specialist.

If you are canceling some or all of your direct deposit accounts, mark cancel on the form and provide the account numbers to be cancelled.

If you cancel all accounts, you will begin receiving your Administaff paycheck as a physical, negotiable check rather than a non-negotiable paystub.

**Q. I want to cancel a direct deposit "balance" account and set up a new direct deposit "balance" account, but I do not want to receive a physical, negotiable paycheck in the interim. What do I do?**

Follow the steps in this order to prevent a physical, negotiable paycheck.

1. To begin a new financial institution account direct deposit:

- Complete and submit the Direct Deposit with ePayStub Enrollment/Change Request for the new financial institution account with a small amount (\$10.00) for deposit.
  - Do not change the amount deposited into the old financial institution account that you will cancel in the future.
2. After the new financial institution account starts to receive funds from Administaff:
    - Complete and submit the Direct Deposit with ePayStub Enrollment/Change Request for the new financial institution account for the "balance" amount.
    - Complete and submit the Direct Deposit with ePayStub Cancellation Request to stop direct deposit to your old financial institution account.
    - You may close your old financial institution account.

**Q. I want to cancel a direct deposit account and set up a new direct deposit account that is not the "balance" account. What do I do?**

Follow the steps in order:

1. To begin a new financial institution account direct deposit:

- Complete and submit the Direct Deposit with ePayStub Enrollment/Change Request for the new financial institution account with a small amount (\$10.00) for deposit.
  - Do not change the amount deposited into the old financial institution account that you will cancel in the future.
2. After the new financial institution account starts to receive funds from Administaff:
    - Complete and submit the Direct Deposit with ePayStub Enrollment/Change Request for the new financial institution account for the amount.
    - Complete and submit the Direct Deposit with ePayStub Cancellation Request to stop direct deposit to your old financial institution account.
    - You may close your old financial institution account.

**Q. What is an ePayStub?**

ePayStub is an online version of a paper paystub. On payday, employees who have elected the ePayStub option may receive an e-mail reminder that their paystub is available online. A paper paystub will not be sent to employees who receive ePayStub. Employees may access their ePayStub online via the Employee Service Center<sup>SM</sup>, a secured web site.

**Note:** The ePayStub option is available only to employees who have elected to be paid by direct deposit. If an employee is paid by a physical, negotiable check for any reason, the employee will receive a paper paystub.

*If you are unsure of any financial information, contact your financial institution to verify before sending your Direct Deposit with ePayStub Enrollment/Change Request to Administaff. If any account information provided is incorrect, it will significantly delay the set up of your direct deposit account(s).*

*If you have additional questions, contact Administaff at 877-804-8978 and select option 2 or by e-mail at [websupport@administaff.com](mailto:websupport@administaff.com).*

### Office Use Only

Prenoted:

### Completion Instructions

- To enroll in direct deposit or make changes to your current direct deposit account(s), complete the employee information and all information for each direct deposit account (up to four accounts).
- Send the completed and signed form to your Administaff payroll specialist.
- For new enrollments and changes, a **voided check** (for checking accounts) or **deposit slip** (for savings accounts) must be attached to this form for verification of routing and transit numbers.
- By completing this form you are electing to receive an ePayStub unless you check the "I do not elect to receive ePayStub" box below.
- CONTACT YOUR FINANCIAL INSTITUTION TO VERIFY ROUTING AND ACCOUNT NUMBERS.**
- ADMINISTAFF WILL NOT BE RESPONSIBLE FOR ANY ERRONEOUS INFORMATION PROVIDED.**

### EMPLOYEE INFORMATION. - Complete all fields.

Employee Name		Social Security Number	
Client Company Name		Client Number	
E-mail Address (Check one for e-mail location for ePayStub reminder.)	<input type="checkbox"/> Home <input type="checkbox"/> Work	Business Phone	Home Phone

### BALANCE ACCOUNT: ☐ NEW ☐ ADD ☐ CHANGE

Financial Institution Name		Area Code & Telephone No.	
Routing/Transit No.	Type Of Account (Check One) <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market Checking <input type="checkbox"/> Money Market Savings		
Account Number	Amount Per Paycheck <input type="checkbox"/> Entire Check <input type="checkbox"/> Balance		

### ADDITIONAL ACCOUNT: ☐ NEW ☐ ADD ☐ CHANGE

Financial Institution Name		Area Code & Telephone No.	
Routing/Transit No.	Type Of Account (Check One) <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market Checking <input type="checkbox"/> Money Market Savings <input type="checkbox"/> 529 College Plan		
Account Number	Amount Per Paycheck \$		

### ADDITIONAL ACCOUNT: ☐ NEW ☐ ADD ☐ CHANGE

Financial Institution Name		Area Code & Telephone No.	
Routing/Transit No.	Type Of Account (Check One) <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market Checking <input type="checkbox"/> Money Market Savings <input type="checkbox"/> 529 College Plan		
Account Number	Amount Per Paycheck \$		

### ADDITIONAL ACCOUNT: ☐ NEW ☐ ADD ☐ CHANGE

Financial Institution Name		Area Code & Telephone No.	
Routing/Transit No.	Type Of Account (Check One) <input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market Checking <input type="checkbox"/> Money Market Savings <input type="checkbox"/> 529 College Plan		
Account Number	Amount Per Paycheck \$		

I hereby elect to receive my paystub electronically. I understand that I can view and print my paystub at any time via the Employee Service Center<sup>SM</sup>, a secured web site. I understand that on my payday I may be sent an e-mail containing a reminder and a secured link to my paystub. I have regular access at work to a nearby computer terminal and printer, provided free of charge, at which I can view and print my paystub, including during working hours. I would like my paystub reminder sent to the e-mail address listed above or other e-mail address that I provide later to Administaff. I understand that I can obtain a written copy of my paystub information at any time by making a request to Administaff. I understand I can revoke this election at any time by forwarding a cancellation form to my Administaff payroll specialist specifying my request. I understand that I can change my e-mail address at any time by completing an Employee Change of Status. ☐ **I do not elect to receive an ePayStub.**

I hereby authorize my employer to initiate deposits (credits) of my net pay and/or corrections to the previous credits to my checking or savings account at the financial institution(s) named on this form. I understand and acknowledge that my election to use this account is completely optional on my part. I understand that I am solely responsible for the accuracy of the information I have submitted on this form. It is my responsibility to notify Administaff of any changes or corrections to my financial institution account information. I understand it will take approximately four weeks to process my enrollment, change or cancellation request from the date received by my Administaff payroll specialist. If I submit a change in financial institution information, I may receive one or more physical, negotiable paychecks until the new financial institution information is processed. In the event of a network electronic failure, I may receive a physical, negotiable paycheck. If I become subject to any attachment, garnishment or levy, my participation in direct deposit may be terminated, and I may receive a physical, negotiable paycheck for my pay. In the event my employment is terminated, the final pay may be a physical, negotiable paycheck. I agree to hold harmless the above named financial institution(s) for any erroneous deposits or adjustments not caused by the financial institution. I agree to hold harmless Administaff for any erroneous deposits or adjustments. I understand that Administaff reserves the right to reverse direct deposit of funds paid in error. I understand that it is my responsibility to verify funds deposited into such account(s) before performing transactions on those funds. Neither Administaff Companies nor

(Client Company)  
are responsible for insufficient funds charges posted to such account(s) due to errors in electronic funds transfer.

<b>SIGN AND DATE THE FORM</b>	Employee Signature	Date
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Employee Name	Last 4 Digits of Social Security No. or	Administaff Employee ID No.
Client Company Name	Client Number	Effective Date (mm/dd/yyyy)

### COMPENSATION REDUCTION

Check one: ☐ Unaccrued use of PTO Amount \$ \_\_\_\_\_ ☐ Overpayment of wages Amount \$ \_\_\_\_\_

### POST-TAX DEDUCTIONS

Description	Amount per Check	Total Dollars	Effective Date	End Date

I HEREBY AUTHORIZE ADMINISTAFF TO MAKE THE ABOVE DESCRIBED DEDUCTION(S)/REDUCTION(S) FROM MY WAGES FOR EACH PAY PERIOD, SUBJECT TO MY RECEIVING MINIMUM WAGE. However, any outstanding balance of a loan pay advance or for unaccrued use of PTO can take my final wages below minimum wage (unless employed in California). I authorize deductions of amounts shown in this form from any amounts due to me, including but not limited to wages, salary, commissions, bonuses, severance, separation pay, expense reimbursements, vacation, sick time paid time off. The above deduction(s)/reduction(s) from my wages or other compensation shall commence on the next payday following the effective date of this authorization and continue each payday thereafter until the entire amount of the underlying obligation for which the deduction/reduction is being made shall have been paid in full, or the benefit or service for which the deduction/reduction is being made is terminated. I understand that any change to the deductions/reduction authorized above must be made in writing and delivered to the Payroll Contact who will in turn deliver to Administaff's Client Services Payroll Specialist at least three days prior to the effective date of the change.

**For all Employees outside of California:** I further agree that, if my employment is terminated the entire remaining balance of the amount due according to the terms of the agreements for which the above described deduction(s)/reduction(s) are authorized may be deducted/reduced from my final wages limited to my receiving minimum wage and if my final wages are insufficient to pay the entire balance, any remaining amount shall be due and payable in full to client company within thirty days thereafter. I understand that any wages advanced to me including in the form of PTO advanced but not accrued will be reduced from my final paycheck upon termination of my employment with said client company and Administaff which may reduce my final wages below minimum wage if not previously reduced prior to my termination.

**For California Employees Only:** I further agree that, if my employment is terminated and there is any remaining balance due on the total amount according to the terms of the agreements for which the above-described deduction(s) are authorized, the remaining balance shall be due and payable in full to client company within thirty days thereafter. I understand that I will be required to sign a separate Deduction Authorization Form at the time of my termination which authorizes the total reduction/deduction of the entire remaining balance amount due from my final wages.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Witness Signature \_\_\_\_\_

### DEDUCTIONS FOR RETIREMENT PLANS ADMINISTERED BY OTHER RECORDKEEPER (ORK)

\*\*\*\***NOT VALID FOR ADMINISTAFF 401(k) PLAN**\*\*\*\*

Please contact your Client Plan Administrator to determine whether you can enroll with a percentage or dollar amount and whether you can enroll for catch-up contributions. (Catch-up contributions applicable for employees age 50 or older only.)

	(check \$ or %) Pre-Tax Amount of gross pay (per paycheck)		(check \$ or %) Roth (After-Tax) Amount of gross pay (per paycheck)
Elective Contributions	<input type="checkbox"/> \$ <input type="checkbox"/> % _____	Elective Contributions	<input type="checkbox"/> \$ <input type="checkbox"/> % _____
Catch-Up Contributions	<input type="checkbox"/> \$ <input type="checkbox"/> % _____	Catch-Up Contributions	<input type="checkbox"/> \$ <input type="checkbox"/> % _____
Total of All Sources	<input type="checkbox"/> \$ <input type="checkbox"/> % _____	Total of All Sources	<input type="checkbox"/> \$ <input type="checkbox"/> % _____

Administaff assumes no responsibility for ensuring that the above authorized payroll deductions are in compliance with the Other Recordkeeper's plan provision or practices, the Internal Revenue Code or corresponding applicable Treasury Regulations. Administaff also assumes no responsibility for the deposit of amounts deducted hereunder into the trust account(s) associated with the Other Recordkeeper's plan, as this remains the responsibility of the Plan Administrator in the plan.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Witness Signature \_\_\_\_\_



**INSTRUCTIONS**

1. **General.** Several state laws require that a deduction from an employee's wages/compensation be authorized in writing by the employee unless the deduction is otherwise authorized or required by law (e.g., income tax withholding, FICA, etc.) or made pursuant to a court order (e.g., a child support garnishment). This form is intended to satisfy the written authorization requirement of these laws. This form may also be used in other states to document that an employee is aware of and consents to a deduction in his/her wages/compensation. A copy of the agreement upon which the deduction authorization is based should be attached to this deduction authorization form whenever possible.
2. **Preparation.** The form should be completed to indicate the amount of a periodic deduction from the employee's wages or other compensation. The most common categories of deductions are indicated on the face of the form, however, a few blank lines have been added to accommodate other categories of deductions. This form should be used if the deduction pertains to a Credit Union, Insurance Plan, or Salary Deferral Plan which is not sponsored or administered by Administaff to evidence authority for Administaff to make the appropriate deduction.
3. **Administaff Benefit Plans, Programs, etc.** If the deduction is for an Administaff sponsored or administered plan, service, or program (e.g., the Administaff Benefit Plan, People's Trust Federal Credit Union, or Administaff 401(k) Plan), it is not necessary to complete this form since the employee's enrollment in those plans or programs includes express authorization for Administaff to make a deduction from the employee's wages/compensation.
4. **Form Retention.** The form should be retained in the payroll records of the employee by the Administaff payroll contact at the Client location to which the employee is assigned for a minimum of twenty-four months following the termination of the deductions described on the form.
5. **Review & Audit.** This form will be a part of Administaff's records which are subject to review and audit by Administaff's Internal Audit Department as well as Administaff's external auditors and must be available to them on demand, to verify proper authorization for deductions from an employee's wages/compensation.
6. **Form Not a Substitute.** This form is not a substitute for, and is not intended to be used in lieu of, any underlying agreement upon which the authorized deduction is based. A separate document should be used to define the terms of any loan, uniform rental, tool purchase, or other agreement for which the payroll deduction is being made.

**Specific to California Employees:**

7. **Deduction from Final Pay.** California law prohibits the employer from deducting the balance of an obligation (previously authorized in writing by the employee) from the final paycheck (a "balloon payment") without a separate written agreement executed at the time of the final paycheck and signed by the employee.